

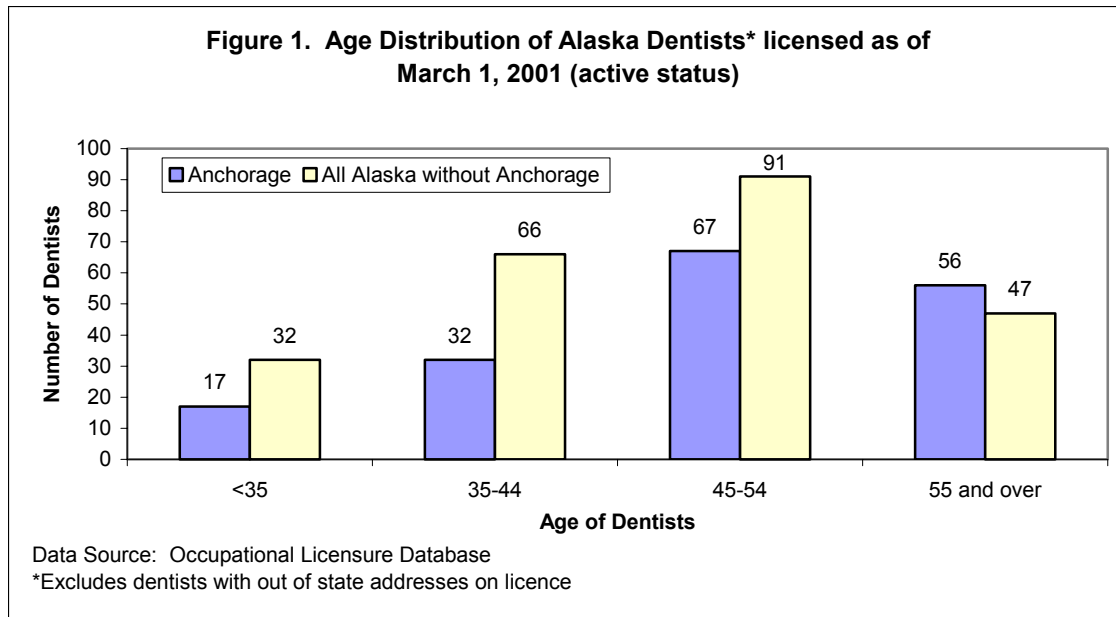
## **Children's Access to Dental Services in Alaska's Denali KidCare/Medicaid Program**

### **BACKGROUND**

Children enrolled in Alaska's Denali KidCare/Medicaid program are experiencing difficulties in accessing dental services. This situation parallels national Medicaid experience in access to dental services. Nationally, fewer than one in five children enrolled in Medicaid programs receive a preventive dental service during the year and the trend is worsening (HRSA, 1998). This is particularly alarming because low-income children experience caries (cavities) at rates far above their wealthier counterparts (Colmers, 1999). In the U.S., 25% of children and adolescents, typically in low-income families, experience 80% of all dental decay occurring in permanent teeth (HRSA, 1998). It is ironic that the children with the greatest need have the least access to dental services and this situation needs attention. In Alaska, young children in remote areas experience early childhood caries (baby-bottle tooth decay) at rates as high as 25% and untreated decay at rates as high as 75% (DHSS, 1994). This has implications for normal development (e.g., nutrition) and success in school.

Nationally, studies indicate the main reasons dentists don't participate more broadly in Medicaid relate to reimbursement rates, administrative "hassles", the rate of non-kept appointments ("no shows") and frustration with the ongoing dental needs of these children (difficulties in changing dietary and dental home care habits which result in recurrent decay). Access is further complicated by a shrinking dental workforce relative to the total population. The supply of newly trained dentists has declined over the last two decades (Colmers, 1999). Over the next twenty years it is projected the ratio of 1 dentist for every 1,725 people will decline to 1 dentist for every 1,925 people. This understates changes in dentistry as dentists have largely reduced practice hours to 32 hours per week and there is an increasing demand for cosmetic and elective dental services. As the available full-time equivalents for dentists decreasing, public programs like Medicaid and S-CHIP have increase the number of children with coverage for dental services. This dynamic has further strained access to dental preventive and treatment services.

Dentists in Alaska reflect these national trends. While there is 1 dentist for every 1,275 Alaskans, they tend to be concentrated in urban areas of the state. What oral health surveillance data is available in Alaska indicates Alaskan children experience caries at an earlier age (DHSS, 1994). This is of concern since most dental practices don't start seeing children until they approach school-age. Alaskan dentists tend to follow the 4-day workweek pattern and almost 50% have been practicing in Alaska for more than 15 years, with 20% practicing longer than 25 years (Rarig, 2001). This same pattern is seen in the age of Alaskan dentists (see Figure 1 below). A similar distribution of ages is seen in dentists practicing in Anchorage; the states major referral area for medical and dental services. Many of these dentists will be retiring from active practice in Alaska over the next decade.



Occupational licensing data indicates an average of 26 new dental licenses are issued in Alaska each year (1995-2000 average). While the rate of increase in dentists in Alaska over this period is almost double the rate of increase in population in Alaska, many of these dentists are buying existing dental practices or serving within the tribal health care system. New dentists that buy existing practices do not dramatically increase access since they inherit an existing caseload of clients. New dentists practicing within the tribal system don't necessarily increase long-term access as there tends to be problems with retention of these providers. The national trend of declining dental providers has also increased recruitment difficulties for dentists in the tribal health systems. If existing patterns continue for dentists seeking licenses in Alaska it is likely more dentists will be retiring or reducing practice hours than will be replaced by full-time equivalent dental providers opening practices in Alaska.

Further, the tribal health care system in Alaska is already experiencing difficulties recruiting and retaining dentist. Even with offering signing bonuses for 3-year commitments the tribal system has vacancies throughout the state. Tribal dental programs already generally have wait lists for dental services as treatment needs exceed the capacity of the dental providers in this system. This has already led to the need to prioritize preventive and treatment services for children over the adult population. Alaska Natives living in remote villages have extremely limited access to dental care except as offered in itinerant dental visits.

While there have been historical difficulties for dental access in Alaska's Medicaid program, the addition of children in Denali KidCare (S-CHIP Medicaid expansion) has put further strain upon the system. While the department has not completed profiling the demographics of the Medicaid-expansion group, indications are that these children tend to be older, live in more urban areas of the state and tend to access dental services at higher rates than the rest of the Medicaid population. This increased demand for dental services may result in practices that were seeing low numbers of Medicaid clients completely closing doors to new clients (at either the request of the dentist or often "in practice" by dental staff answering phones). It also places further

demands and longer waiting times in practices that are still seeing “new” clients. On a positive note, however, the increased demand for dental services and/or loss of existing self-pay clients from practices when dentists don’t accept Denali KidCare/Medicaid has caught the attention of a number of dentists and stimulated active discussions between the state dental association and the Medicaid program.

Alaskan dentists have voiced similar concerns about Medicaid as those heard in national forums. Their concerns include:

- Patient compliance (following home care instruction and keeping appointments);
- Lower reimbursement rates for Medicaid than for self-pay and patients with dental insurance;
- Administrative hassles with claims processing; and
- Fears around fraud/abuse investigations

More specific to Alaska dentists are concerned about:

- Interpretation concerns with the hold harmless clause in the provider enrollment agreement that they believe may make them liable for defending the state in joint legal actions; and
- Compromised care in the adult Medicaid program given the services that are covered.

Access to dentists in Alaska also faces non-financial barriers to care. Residents of small villages in Alaska only have access to dental services on an itinerant basis or through transportation to regional hub communities and/or urban areas for treatment services. Many residents in these areas lack the benefit of community water fluoridation and given significant changes in diet from the traditional subsistence diet, many children experience rampant decay at young ages (early childhood caries). The combination of high caries rates and low access to routine dental care often means the dental providers available are often overwhelmed by treatment needs and lack time for adequate training and education on prevention of dental diseases.

### **WHAT IS DHSS DOING ABOUT INCREASING ACCESS TO DENTAL CARE?**

The Alaska Medicaid program primarily operates through provision of services by the private sector. Since, in the short-term, access improvements will rely primarily in increased participation in Medicaid by private dentists the department has initiated a number of efforts to address private dental concerns in Medicaid. These include:

#### **Additional features to streamline claims processing for dentists:**

- Removed MMIS services limits for routine dental exams for children (a source of review or denial of dental claims)
- Streamlined claims processing – The Division of Medical Assistance’s Fiscal Agent facilitating claim correction to increase prompt payment of claims.
- Changed MMIS system edits to “pend” claims and assisting dentists to make corrections to claims, rather than denying these claims.

- Approval of a third-party liability (TPL) waiver from HCFA that allows DMA to pay dental claims and “chase” other third-party payers for reimbursement to Medicaid.
- The Division of Medical Assistance (DMA) is undertaking work with the dental community to standardize the dental electronic claim form in order to speed claims processing.
- DMA is undertaking work to increase availability of electronic billing for dental claims (e.g., use of the Internet is being finalized).
- DMA is also working with its Fiscal Agent to make the provider (dental) billing manual more user-friendly and working to increase provider training sessions.

**Address dentist’s legal concerns with the Medicaid program:**

- The Department has received an Attorney General’s office opinion that “hold-harmless” provisions of provider enrollment do not relate to a provider burden to defend the “State of Alaska” in legal cases related to Medicaid, rather

“The clause is intended to make clear that the State of Alaska bears no responsibility for liability arising from the services provided by the provider to the recipient.” (Bomengen, 1999)

The Division of Medical Assistance is consulting with the Attorney General’s Office to determine if language revisions are required in the provider enrollment application to clarify this issue.

- The Department consulted with the Attorney General’s office for guidance to providers that provision of dental services to children enrolled in Medicaid, while not offering services to adults enrolled in Medicaid, does not in and of itself constitute “discrimination”.
- DMA is also working to ensure timely responses to providers on the status of provider audits and provide additional information on audit procedures and issues to all providers. While audits are part of the imposed administrative structure for the Medicaid program, improvement is needed so providers don’t discontinue participation in Medicaid due to the perceived administrative burden of audits on practices. Providers have also indicated that inadequate or untimely feedback regarding Medicaid audits result in stress associated with the implications for repayments to Medicaid, fines or other civil/criminal actions.

The state dental association would still like to see any language that implicates that a provider might be responsible for defending the State in a suit filed jointly against the provider and state removed from the provider agreement. The State expects to make some revisions to the enrollment agreement in conjunction with the MMIS procurement and re-enrollment of providers. The dental association is also concerned regarding the implications of special discounted arrangements for seniors, self-pay, and other low-income patients that don’t constitute fraud in the Medicaid program.

### **Improving dental awareness and activities to address non-kept appointments (“no shows”)**

- The Medicaid Services Unit, Division of Public Health, has included dental education components and information on the importance of keeping appointments as subject areas in monthly newsletters to parents of children enrolled in Medicaid (EPSDT outreach effort).
- The Medicaid Services Unit funded a “dental access” pilot in FY2000 in the Kenai/Soldotna area of the state that incorporated dental education, education on keeping appointments, and assistance to clients in making dental appointments as a means to involve low-participating dentists in seeing new Medicaid clients in their practices. The project resulted in a community dental needs assessment and current discussion of application for a community health center.
- The Division of Medical Assistance is developing a recipient training program and recipient benefits guide, both stressing appropriate use of benefits.

### **Other initiatives**

- DMA will be reviewing transportation services and processes as they relate to increasing access to services. Transportation services are provided to children needing dental services (even routine dental services) when services are not available within their home community. Transportation is frequently required when the services of a specialist are indicated.
- DMA is in the process of procuring a new Medicaid Management Information System and fiscal intermediary contract. It is hoped the new system and vendor will offer an opportunity to improve provider and recipient relations and services.
- The Division of Public Health, Section of Community Health and Emergency Medical Services (CHEMS), is working on updating dental under-served areas (dental HPSAs) to assist in recruitment of National Health Service Corps dentists and assist in federal student loan repayment programs.
- The department is looking to establish a full-time dental director position to work on oral health surveillance, and access issues, including continued work with DMA on improving dental access in the Medicaid/Denali KidCare program.

### **Reimbursement Policy**

Unlike many other states, Alaska has not chosen reimbursement policy as the starting point for increasing access to dental services. In part, this is because Alaska’s dental reimbursements are already much higher than other states. In the last dental fee update (1998) DMA attempted to maintain dental reimbursements at 80% of Usual, Customary and Reasonable (UCR) fees. A review of a Medicaid Survey by Dr. Burt Edelstein of the Children’s Dental Health Project revealed Alaska’s dental reimbursement for routine dental services provided to children was generally highest of any state and most often twice the national average reimbursement for these procedures. (Edelstein, 1998) Still dentist’s complain they have to “pay” to see Medicaid/Denali KidCare recipients, due to the cost of office overhead as it relates to reimbursement and administrative hassles with claims.

The department's interest is to see if the other changes mentioned above stimulate more active participation of private dentists in the program. Dialogue with the state dental association has indicated administrative issues with the program and "no shows" are the two major contributors to failure of dentists in seeing new Medicaid clients and/or discontinuing participation in the program. The association has also mentioned concerns with the hold harmless clause of the provider agreement (discussed previously). The dental association, however, has indicated interest in seeing reimbursement rates increased. A number of states, at this time, have increased their reimbursement rates to 80-85% of UCR for their areas (that doesn't necessarily mean at reimbursement rates higher than Alaska's). National studies, however, have indicated increased reimbursement does not dramatically increase access to services for more children. Higher reimbursement levels does increase the amount of services provided to Medicaid children who are already seeing dentists (Colmers, 1999).

Discussions with dentists and the state dental association seem to indicate dentists may not dramatically increase availability to dental services for "new" Medicaid clients even at 100% of UCR given:

- Many dentists are not expanding their practices (they have enough clients already)
- Medicaid clients are more burdensome on practices (no shows, younger children than they generally see, and problems with patient compliance on improved oral health)
- A significant number of the dentists are nearing retirement
- Their dissatisfaction with adult "Medicaid" dental services (limited by state law to emergency services) and perceptions of some "drug-seeking" behavior of adult Medicaid clients
- Their past perceptions with the Medicaid program and experiences with clients

Nevertheless, in the next year the department may consider a review of the reimbursement policy for dental services. As many states have indicated, increasing reimbursement for dental services would be easier if there were a higher federal match rate for these services (recommendations have been to increase federal match to 90% as is available for family-planning activities). As a short-term solution the department may be faced with looking to contract (professional contracts) for dental services to increase access to services.

### **Tribal dental perspectives**

The dental directors for the tribal health system (Native Health Corporations) have prepared a discussion paper on dental access ([Crisis in Access to Dental Care](#)). This paper was presented to Native health corporation director's at their February 2000 meeting and adopted by the Alaska Native Tribal Health Consortium. This paper points to the need for:

- increased dental education/prevention to decrease the unmet need for services;
- increased federal funding for dental positions (e.g., hygienists which aren't built into federal IHS baselines);
- increased federal funding for hiring of more dental specialists (e.g., pediatric dentists);

- increased capability for federal salary bonuses as a means to assist in recruitment and retention of dentists; and
- more flexible state licensure laws for expanded function dental assistants and/or temporary licenses to dentists/dental specialists/hygienists from other states.

### **RECENT TRENDS**

Tables 1 and 2 show children's dental utilization in FFY2000 and FY1999 as reflected on the HCFA 416 reports for these periods.

**TABLE 1**

### **Dental Utilization - Children in Enrolled in Medicaid FFY2000 (October 1, 1999 - September 30, 2000)**

<b>Scenario #1: Assuming continuous eligibility</b>										
	Total	Total w/o <1 year	Total 3-20	<1	1-2	3-5	6-9	10-14	15-18	19-20
Any dental service	33.5%	36.1%	40.8%	0.3%	7.8%	36.9%	46.9%	44.7%	37.5%	21.6%
Dental preventive services	26.5%	28.6%	32.6%	0.1%	4.2%	27.4%	39.4%	37.8%	28.4%	12.6%
Dental treatment services	18.6%	20.1%	23.0%	0.0%	2.6%	17.4%	26.4%	24.4%	24.7%	15.7%
Number of children	75,319	69,841	59,998	5,478	9,843	11,893	15,610	17,123	11,171	4,201
	Total	Total w/o <1 year	Total 3-20	<1	1-2	3-5	6-9	10-14	15-18	19-20
<b>Scenario #2: Actual average period of eligibility from HCFA 416</b>										
Any dental service	45.3%	48.2%	54.4%	0.5%	10.1%	48.5%	60.2%	57.4%	51.3%	38.0%
Dental preventive services	35.9%	38.2%	43.5%	0.2%	5.5%	36.1%	50.5%	48.4%	38.9%	22.0%
Dental treatment services	25.2%	26.8%	30.6%	0.1%	3.3%	22.8%	33.9%	31.3%	33.8%	27.5%

**TABLE 2**

**Dental Utilization - Children in  
Enrolled in Medicaid  
FFY1999 (October 1, 1998 -  
September 30, 1999)**

<b>Scenario #1: Assuming continuous eligibility</b>										
	Total	Total w/o <1 year	Total 3-20	<1	1-2	3-5	6-9	10-14	15-18	19-20
Any dental service	30.0%	32.5%	33.6%	0.3%	6.7%	33.1%	42.3%	40.1%	34.0%	21.7%
Dental preventive services	23.5%	25.4%	26.5%	0.1%	4.0%	24.3%	35.1%	33.7%	24.7%	12.0%
Dental treatment services	16.5%	17.8%	18.7%	0.1%	2.0%	15.6%	23.4%	21.5%	22.4%	15.6%
Number of children	65,400	60,372	56,679	5,028	8,721	10,778	14,057	14,263	8,793	3,760
<b>Scenario #2: Actual average period of eligibility from HCFA 416</b>										
Any dental service	43.5%	45.8%	52.5%	0.7%	9.2%	46.0%	58.0%	55.6%	50.7%	36.8%
Dental preventive services	34.0%	35.8%	41.4%	0.2%	5.5%	33.8%	48.2%	46.8%	36.9%	20.4%
Dental treatment services	23.9%	25.1%	29.2%	0.2%	2.8%	21.7%	32.0%	29.9%	33.5%	26.4%

These tables reflect dental utilization in crude rates, rates adjusted for the state referral schedule for dental service (at age 3) and the average period of eligibility. Adjusted for these factors, child dental access as measured by children receiving any dental service in FFY1999 was 43.5%. For this same period, child dental access to preventive dental services was 34% and for dental treatment services the utilization rate was 23.9%. In FY2000 all of these dental utilization rates increased slightly. Children receiving any dental service increased to 45.3%, for preventive dental services the rate increased to 35.9% and for dental treatment services it increased to 25.2%. The slight increase in receiving dental services is seen across all age groups with the exception of those children under age 1.



While the dental utilization as measured by these rates of children receiving dental services is moving in the right direction, they are very small increases. It is difficult to discern how much of the increased use of dental services is the result of the above-mentioned efforts and how much relates to higher service utilization of the S-CHIP population in the Medicaid program. Further, concern remains about future dental access issues given dental provider demographics in the state and the national gap of graduating dentists to replace those retiring or reducing practice hours. These issues may be more severe in states like Alaska that are predominately rural and lack a dental school. It is unlikely Alaska, on its own, can address these issues of provider supply, distribution and practice patterns.

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